SAMPLE

Indiana Health Coverage Programs

BILLING PROVIDER ENROLLMENT APPLICATION

Please read carefully

Dear Prospective Provider,

On behalf of EDS and the Office of Medicaid Policy and Planning, thank you for your interest in becoming a provider in the Indiana Health Coverage Programs (IHCP). Enclosed is an application for enrollment as a billing provider in the IHCP. A separate application must be completed for each service location you are enrolling.

The IHCP Billing Provider Enrollment Application is divided into Schedules A, B, C.1 (Institutional Providers), C.2 (Transportation Providers), and the Provider Agreement. Please refer to ***Attachment A*** for the provider specialty list. Refer to ***Attachment B*** to determine which schedules you need to complete and the required licensing for each provider type/specialty. The application contains instructions for completion. Please read the application carefully and answer each question completely. If a field is not applicable, please write N/A in the field. **Failure to complete a required section or enclose copies of the required licenses, certifications, and other required documentation will result in the application being returned to you for additional information and will delay the enrollment process.**

When should the Billing Provider Enrollment Application be used?

A Billing Provider Enrollment Application must be used when:

- **Enrolling a sole proprietorship location with only one practitioner providing services.** A sole proprietorship is defined as a provider who owns a practice location where he or she is the sole practitioner performing services.
- **Enrolling a group location.** A group is defined as a business entity that owns one or more service locations where practitioners are employed or contracted to perform professional services on behalf of the business entity. Each business entity and service location where services are rendered to IHCP members must be enrolled in the program.

Note: *The group must enclose Group Member Enrollment Applications for all group members (rendering practitioners) along with the Billing Provider Enrollment Application for the group. Provider Enrollment will not enroll a group location without the associated rendering practitioners' Group Member Enrollment Applications.*

- **Enrolling a facility location.** A facility or organization is a location such as a hospital, surgery center, long term care facility, or pharmacy. Transportation providers are also included in this classification.

Mailing Instructions

Once you have fully completed the application, signed the provider agreement, enclosed copies of all required licenses, forms, W-9, and certifications, please mail the entire packet to:

EDS – Provider Enrollment
P.O. Box 7263
Indianapolis, IN 46207-7263

Once Provider Enrollment receives and reviews your enrollment application and agreement, we will notify you in writing of the status of your enrollment. Please allow 15 business days for mailing and processing time.

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Questions

Please visit our web site at www.indianamedicaid.com or contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 with any questions about this application.

Note: *Any changes in information reported in this application must be reported to EDS within ten days of the change. Failure to notify EDS of changes may result in:*

- *Misdirected payments and/or bulletins*
- *Incorrect 1099 information*
- *Denied claims*
- *Termination of the provider's IHCP eligibility without advance notice*

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Indiana Health Coverage Programs

BILLING PROVIDER ENROLLMENT APPLICATION

Schedule A – Provider Information

1. Which of the following best describes this provider location?

Please check the box that best describes the provider location being enrolled. **Only one** box may be checked.

☐ Group Practice ☐ Facility or Organization ☐ Sole Practitioner

2. Service Location Name and Address

Please complete the Name, Telephone Number, Address, and ZIP Code for the site where services will be performed. You must complete a separate application for each location where services are performed, even if you bill claims from all locations under one provider number. Except for sole proprietors who use their own legal names for business purposes, each service location name must be the Doing Business As (DBA) name registered with the Secretary of State. The address must be a physical location. A post office box is not a valid service location address.

Are you registered with the Secretary of State? ☐ Yes ☐ No

DBA Name _____ Telephone _____

Street Address _____

City _____ State _____ ZIP _____

*Taxpayer Identification Number for this Service Location: _____

*NOTE: A copy of a completed Federal W-9 Form must be attached with this form. Failure to attach this form will result in EDS returning this form for incomplete information.

3. Legal Name and Home Office Address

Please complete the contact information for the home office of the legal entity maintaining ownership of this service location. The legal name must be the current name on tax, corporation, and other legal documents, and currently registered with the Secretary of State. The address must be a physical location. A post office box is not a valid home office address. If there is more than one legal name currently used by this business entity, attach an explanation listing each name, address, and tax ID number.

Legal Name _____ Telephone _____

Street Address _____

City _____ State _____ ZIP _____

Tax ID Number _____

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Schedule A Continued

4. Mailing Name and Address

Please complete the contact information for the addressing of bulletins, provider manual updates, and general correspondence. A post office box is acceptable for a mailing address.

Name _____ Telephone _____

Address _____

City _____ State _____ ZIP _____

5. Pay To Name and Address

Please complete the contact information for the addressing of checks, remittance advices, and general claims payment information. If this is a billing agent's address, please provide the name, address, and phone number of the billing agent. A post office box is acceptable for this address.

Name _____ Telephone _____

Address _____

City _____ State _____ ZIP _____

Billing Agent? ☐ Yes ☐ No

6. E-mail Address

Please provide the e-mail address that is a primary contact for the service location.

E-mail Address: _____

7. Provider Licensing Information

Note: Sections 7-10 require copies of the following documents for verification as applicable. Please see Attachment B for specific requirements by provider type.

- Provider License from Licensing Board
- Clinical Laboratory Improvement Amendment (CLIA) Certificate
- Federal Drug Enforcement Administration (DEA) Certificate
- Medicare Provider Number Assignment Letter for Medicare Participation

Please complete the information about your licensure as determined and maintained by the official licensing board for your provider type and specialty. Refer to Attachment A to determine the provider type and specialty numbers for your primary and secondary specialty. Refer to Attachment B for the enrollment requirements for the provider type and specialties selected.

Provider Type _____

Primary Specialty _____ Secondary Specialty _____

Primary Sub-Specialty _____ Secondary Sub-Specialty _____

License Number _____ Licensing Board _____

License Effective Date _____ License Expiration Date _____

Note: A copy of the license from the appropriate licensing board must be attached to the application. Failure to attach a copy of the license will result in EDS returning this application for incomplete information.

Note: You may select only one provider type. If you want to enroll more than one type, a separate application must be completed for each type. Primary and secondary specialties must be listed under the same provider type on Attachment A.

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Schedule A Continued

8. CLIA Certification

Please complete this section with the information from your Clinical Laboratory Improvement Amendment (CLIA) Certificate.

CLIA Number _____ Certification Type _____

Effective Date _____ Expiration Date _____

Note: A Copy of the certificate must be attached to the application. Failure to attach a copy of the certificate will result in denied claims for laboratory services.

9. Federal DEA Certification

Please complete this section with the information from your Federal Drug Enforcement Administration (DEA) Certificate.

DEA Number _____

Effective Date _____ Expiration Date _____

Note: A copy of the certificate must be attached to the application. Failure to attach a copy of the certificate will result in denied claims for prescriptions you prescribe.

10. Medicare Participation

Please complete the appropriate Medicare identification numbers.

Medicare Number _____ Medicare Number State _____

Universal Provider Identification Number (UPIN) _____

DME Supplier Number _____

Note: A copy of the Medicare Number assignment letter (or Medicare RA with correct Medicare number) must be attached to the application. Failure to attach a copy of the letter may result in denied Medicare Crossover claims.

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Schedule A Continued

11. Are you currently, or have you ever been enrolled as an IHCP provider?

If you are currently, or have ever been enrolled as an IHCP or Medicaid provider, please check the box labeled yes and list the provider number(s) you were assigned.

Yes ☐ No ☐ If yes, please indicate all current and previous IHCP or Medicaid numbers:

_____ _____ _____

_____ _____ _____

12. Do you wish to participate in the Health Watch program?

HealthWatch is a preventative health care program offered to Medicaid eligible recipients under 21 years of age. Physicians or nurse practitioners who are enrolled as Medicaid providers are qualified to perform HealthWatch screens. Reimbursement for HealthWatch services is higher than equivalent services billed using standard CPT codes. HealthWatch screens must be completed in accordance with recommendations set forth in the HealthWatch Provider Manual Periodicity Schedule. Check the box labeled yes if you wish to participate in this program.

Yes ☐ No ☐

13. Do you wish to participate in the 590 program?

The 590 Program is a State medical assistance program providing reimbursement for medically necessary covered medical services provided off site to individuals who reside in State institutions. Check the box labeled yes if you wish to participate in this program.

Yes ☐ No ☐

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Schedule B – Organization Structure

1. How is this provider entity legally organized and structured?

Check the entity type that best describes the structure of the enrolling provider entity. Please check **only one** box**.**

☐ For Profit Corporation ☐ Partnership ☐ Sole Proprietorship

☐ Not-for-Profit Corporation ☐ Government Owned

2. Peer group or locality

Please check the peer group or locality that best describes the service location. Please check **only one** box.

☐ Metropolitan ☐ Rural ☐ Urban ☐ Teaching (Hospitals only)

3**. Is this entity chain affiliated?**

If yes, complete the information in item 5 below.

Yes ☐ No ☐

4. Is this entity operated by a management company, or leased in whole or part by another organization?

If yes, complete the information in item 5 below.

Yes ☐ No ☐

5. List all owners and officers of the business entity

List below the Name, Title, Social Security Number, and Address of each Officer and/or individual who owns five percent or more of the provider entity, and the Name, Tax ID (TIN), and Address of any organization, corporation, or entity having direct or indirect ownership or controlling interest in the provider entity. Attach additional pages as necessary to list all officers, owners, management and ownership entities.

Name	SSN or TIN if organization	Address
Relationship or Title		
Name	SSN or TIN if organization	Address
Relationship or Title		
Name	SSN or TIN if organization	Address
Relationship or Title		

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Schedule B Continued
6. Has there been a change in ownership or control within the past year, or is a change of ownership anticipated? If yes, you must submit the enclosed CHANGE OF OWNERSHIP ADDENDUM form for the current provider entity, and a new application for the new ownership entity. Yes ☐ No ☐
7. Has there been a past bankruptcy or do you anticipate filing for bankruptcy within a year? Yes ☐ No ☐ If yes, when? _____
8. Background Information Has any agent, managing employee, or owner of the provider entity been excluded from or convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs? Yes ☐ No ☐ If yes, state below the Name, SSN, and position within the provider entity: _____ _____ _____

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Schedule C.1 Institutional Providers
Enrollment of institutional providers surveyed and licensed by the Indiana State Department of Health (ISDH) is dependent upon EDS receiving a completed Certification and Transmittal from the ISDH. The ISDH must survey each institutional provider to determine whether federal and state qualifications to participate in the IHCP are met.
1. Have you completed the ISDH survey process? ☐ **Yes** ☐ **No** If you answered No, you must contact ISDH to complete the survey process prior to enrolling in the IHCP.
Section A – Hospitals
2. If the provider is a hospital, are the requirements of *42 USC Section 1395ww(d)(5)(D)(iii)* met for the hospital to qualify as a sole community hospital? If you satisfy the requirements of 42 USC Section 1395ww(d)(5)(D)(iii) to qualify as a sole community hospital, please check Yes. Otherwise, please check No. ☐ Yes ☐ No
Section B – Long Term Care Facilities
3. Are you enrolling in Medicaid **solely** to be reimbursed for services provided to Qualified Medicare Beneficiaries (QMB) in long term care facilities? ☐ Yes ☐ No

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Schedule C.2 – Transportation Providers

1. Type of Service (indicate all that apply)

Please check all of the services provided by this location. You may select more than one box.

☐	Common Carrier (Ambulatory)	☐	Ambulance	☐	Taxicab
☐	Common Carrier (Non-ambulatory)	☐	Air Ambulance	☐	Bus
☐	Family Member/Volunteer Transportation				

2. Please Attach All That Apply

For each box checked in number 1 above, please include all of the attachments shown below

	Attachment included? Yes	No
Ambulance or Air Ambulance:		
Emergency Medical Services Commission (EMS) Certification	☐	☐
Bus		
Motor Carrier Services (MCS) Certification	☐	☐
Common Carrier Ambulatory or Non-Ambulatory (for profit):		
Motor Carrier Services (MCS) Certification	☐	☐
Common Carrier Ambulatory or Non-Ambulatory (not-for-profit):		
Certification of not-for-profit status from the IRS	☐	☐
Proof of insurance ($500,000 combined single limit commercial automobile liability insurance is required)	☐	☐
Taxicabs:		
Operating agreement from local governing body	☐	☐
Proof of insurance as indicated by local ordinances (if unspecified by local ordinance, a minimum of $25,000/$50,000 public livery insurance covering all vehicles used in the business)	☐	☐
Family Member/Volunteer Transportation:		
Proof of insurance as specified by Indiana state law	☐	☐
Appropriate and valid driver's licenses as specified by Indiana state law	☐	☐
Certification from the County Division of Family and Children Office for the IHCP member	☐	☐

Note: Failure to attach the necessary attachments will result in EDS returning this application for incomplete information.

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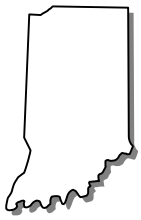
Office of Medicaid Policy and Planning, Office of the Children's Health Insurance Program



MEDICAID/CHILDREN'S HEALTH INSURANCE PROGRAM PROVIDER AGREEMENT

By execution of this Agreement, the undersigned entity ("Provider") requests enrollment as a provider in the Indiana Health Coverage Programs. As an enrolled provider in the Indiana Health Coverage Programs, the undersigned entity agrees to provide Medicaid-covered and Children's Health Insurance Program (CHIP)-covered services and/or supplies to Indiana Medicaid and Indiana CHIP members. As a condition of enrollment, Provider agrees to the following:

1. To comply, on a continuing basis, with all enrollment requirements established under rules adopted by the State of Indiana Family and Social Services Administration ("IFSSA").
2. To comply with all federal and state statutes and regulations pertaining to the Medicaid Program or CHIP, as they may be amended from time to time.
3. To meet, on a continuing basis, the state and federal licensure, certification or other regulatory requirements for Provider's specialty including all provisions of the State of Indiana Medical Assistance law, State of Indiana Children's Health Insurance Program law, or any rule or regulation promulgated pursuant thereto.
4. To notify IFSSA or its agent within ten (10) days of any change in the status of Provider's license, certification, or permit to provide its services to the public in the State of Indiana.
5. To provide Medicaid-covered and CHIP-covered services and/or supplies for which federal financial participation is available for Medicaid and CHIP members pursuant to all applicable federal and state statutes and regulations.
6. To safeguard information about Medicaid and CHIP members including at a minimum:
   - a. members' name, address, and social and economic circumstances;
   - b. medical services provided to members;
   - c. members' medical data, including diagnosis and past history of disease or disability;
   - d. any information received for verifying members' income eligibility and amount of medical assistance payments;
   - e. any information received in connection with the identification of legally liable third party resources.
7. To release information about Medicaid and CHIP members only to the IFSSA or its agent and only when in connection with:
   - a. providing services for members; and
   - b. conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the provision of Medicaid-covered and CHIP-covered services.
8. To maintain a written contract with all subcontractors which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract. No subcontract, however, terminates the legal responsibility of the contractor to the agency to assure that all activities under the contract are carried out.
9. To submit claims for services rendered by the provider or employees of the provider and not to submit claims for services rendered by contractors unless the provider is a healthcare facility (such as hospital, ICF-MR, or nursing home), or a government agency with a contract that meets the requirements described in item 8 of this Agreement. Healthcare facilities and government agencies may, under circumstances permitted in federal law, subcontract with other entities or individuals to provide Medicaid-covered and CHIP-covered services rendered pursuant to this Agreement.
10. To comply, if a hospital, nursing facility, provider of home health care and personal care services, hospice, or HMO; with advance directive requirements as required by *42 Code of Federal Regulations, parts 489, subpart I, and 417.436*.

11. To abide by the Indiana Health Coverage Programs Provider Manual, as amended from time to time, as well as all provider bulletins and notices. Any amendments to the Provider Manual, as well as provider bulletins and notices, communicated to Provider shall be binding upon receipt. Receipt of amendments, bulletins and notices by Provider shall be presumed when mailed to the billing Provider's current "mail to" address on file with IFSSA or its fiscal agent.

12. To submit timely billing on Medicaid and CHIP approved claim forms, as outlined in the Indiana Health Coverage Programs Provider Manual, bulletins, and banner pages, in an amount no greater than Provider's usual and customary charge to the general public for the same service.

13. To be individually responsible and accountable for the completion, accuracy, and validity of all claims filed under the provider number issued, including claims filed by the Provider, the Provider's employees, or the Provider's agents. Provider understands that the submission of false claims, statements, and documents or the concealment of material fact may be prosecuted under the applicable Federal and/or State law.

14. To submit claim(s) for Medicaid or CHIP reimbursement only after first exhausting all other sources of reimbursement as required by the Indiana Health Coverage Programs Provider Manual, bulletins, and banner pages.

15. To submit claim(s) for Medicaid or CHIP reimbursement utilizing the appropriate claim forms and codes as specified in the provider manual, bulletins and notices.

16. To submit claims that can be documented by Provider as being strictly for:
- a. medically necessary medical assistance services;
- b. medical assistance services actually provided to the person in whose name the claim is being made; and
- c. compensation that Provider is legally entitled to receive.

17. To accept payment as payment in full the amounts determined by IFSSA or its fiscal agent, in accordance with federal and state statutes and regulations as the appropriate payment for Medicaid or CHIP covered services provided to Medicaid or CHIP members (recipients.) Provider agrees not to bill members, or any member of a recipient's family, for any additional charge for Medicaid or CHIP covered services, excluding any co-payment permitted by law.

18. To refund within fifteen (15) days of receipt, to IFSSA or its fiscal agent any duplicate or erroneous payment received.

19. To make repayments to IFSSA or its fiscal agent, or arrange to have future payments from the Medicaid program and CHIP withheld, within sixty (60) days of receipt of notice from IFSSA or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made, unless an appeal of the determination is pending. A hospital licensed under *IC 16-21* has one hundred eighty (180) days to repay.

20. To pay interest on overpayments in accordance with *IC 12-15-13-3*, *IC 12-15-21-3*, and *IC 12-15-23-3*.

21. To make full reimbursement to IFSSA or its fiscal agent of any federal disallowance incurred by IFSSA when such disallowance relates to payments previously made to Provider under the Medicaid Program or CHIP.

22. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.

23. To make available upon demand by federal and state officials and their agents all records and information necessary to assure the appropriateness of Medicaid and CHIP payments made to Provider, to assure the proper administration of the Medicaid Program and CHIP, and to assure Provider's compliance with all applicable statutes and regulations. Such records and information are specified in *405 IAC 1-5* and in the Indiana Health Coverage Programs Provider Manual, and shall include, without being limited to, the following:
- a. medical records as specified by *Section 1902(a)(27)* of Title XIX of the Social Security Act, and any amendments thereto;
- b. records of all treatments, drugs and services for which vendor payments have been made, or are to be made under the Title XIX or Title XXI Program, including the authority for and the date of administration of such treatment, drugs or services;
- c. any records determined by IFSSA or its representative to be necessary to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program or Indiana CHIP;

- d. documentation in each patient's record that will enable the IFSSA or its agent to verify that each charge is due and proper;
- e. financial records maintained in the standard, specified form;
- f. all other records as may be found necessary by the IFSSA or its agent in determining compliance with any Federal or State law, rule, or regulation promulgated by the United States Department of Health and Human Services or by the IFSSA.

24. To cease any conduct that IFSSA or its representative deems to be abusive of the Medicaid program or CHIP.

25. To promptly correct deficiencies in Provider's operations upon request by IFSSA or its fiscal agent.

26. To file all appeal requests within the time limits listed below. Appeal requests must state facts demonstrating that:
- a. the petitioner is a person to whom the order is specifically directed;
- b. the petitioner is aggrieved or adversely affected by the order;
- c. the petitioner is entitled to review under the law.

27. Provider must file a statement of issues within the time limits listed below, setting out in detail:
- a. the specific findings, actions, or determinations of IFSSA from which Provider is appealing;
- b. with respect to each finding, action or determination, all statutes or rules supporting Provider's contentions of error.

28. Time limits for filing an appeal and the statement of issues are as follows:
- a. A hospital licensed under *IC16-21* must file an appeal of any of the following actions within one hundred eighty (180) days of receipt of IFSSA's determination:
- (1) A notice of program reimbursement or equivalent determination regarding reimbursement or a year end cost settlement.
- (2) A notice of overpayment.
- (3)The statement if issues must be filed with the request for appeal.
- b. Other providers must file an appeal of determination that an overpayment has occurred within 60 days of receipt of IFSSA's determination. The statement of issues must be filed within 60 days of receipt of IFSSA's determination.
- c. All appeals of actions not described in (a) or (b) must be filed within 15 days of receipt of IFSSA's determination. The statement of issues must be filed within 45 days of receipt of IFSSA's determination.

29. To cooperate with IFSSA or its agent in the application of utilization controls as provided in federal and state statutes and regulations as they may be amended from time to time.

30. To comply with civil rights requirements as mandated by federal and state statutes and regulation by ensuring that no person shall, on the basis of race, color, national origin, ancestry, disability, age, sex or religion, be excluded from participation in, be denied the benefits of, or be otherwise subject to discrimination in the provision of a Medicaid-covered or CHIP-covered service.

31. To comply with *42 Code of Federal Regulations, part 455, subpart B* pertaining to the disclosure of information concerning the ownership and control of the provider, certain business transactions, and information concerning persons convicted of crimes. Said compliance will include, but is not limited to, giving written notice to IFSSA, or its fiscal agent, at least sixty (60) days before making a change in any of the following: Name (legal name, DBA name, or name as registered with the Secretary of State), address (service location, "pay to," "mail to,",or home office), federal tax identification number(s), or change in the provider's direct or indirect ownership interest or controlling interest. Pursuant to *42 Code of Federal Regulations, part 455.104(c),* OMPP must terminate an existing provider agreement if a provider fails to disclose ownership or control information as required by federal law.

32. To furnish to IFSSA or its agent, as a prerequisite to the effectiveness of this Agreement, the information and documents set out in Schedules A through D to this Agreement, which are incorporated here by reference, and to update this information as it may be necessary.

33. That subject to item 32, this Agreement shall be effective as of the date set out in the provider notification letter.

34. That this Agreement may be terminated as follows:
- a. By IFSSA or its fiscal agent for Provider's breach of any provision of this Agreement as determined by IFSSA; or

– b. By IFSSA or its fiscal agent, or by Provider, upon 60 days written notice.

35. That this Agreement has not been altered, and upon execution, supersedes and replaces any provider agreement previously executed by the Provider.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, HEREBY AGREES, BOTH INDIVIDUALLY AND ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.

THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY MEDICAID OR CHIP RELATED OFFENSE AS SET OUT IN *42 USC 1320a-7b* MAY BE PUNISHABLE BY A FINE OF UP TO $25,000 OR IMPRISONMENT OF UP TO FIVE YEARS OR BOTH.

Provider-Authorized Signature – All Schedules
The owner or an authorized officer of the business entity must complete this section.
I certify, under penalty of law, that the information stated in Schedules A, B, C.1, and C.2 is correct and complete to the best of my knowledge. I am aware that, should an investigation at any time indicated that the information has been falsified, I may be considered for suspension from the program and/or prosecution for Medicaid Fraud. I hereby authorize the Indiana Family and Social Services Administration to make any necessary verifications of the information provided herein, and further authorize and request each education institution, medical/license board or organization to provide all information that may be required in connection with my application for participation in the Indiana Health Coverage Programs and the Indiana Children's Health Insurance Programs. Provider DBA Name _____ Tax ID _____ Officer Name _____ Title _____ Signature _____ Date _____ Telephone Number _____
Note: Failure to complete this section will result in EDS returning the application for incomplete information.

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Indiana Health Coverage Programs

BILLING PROVIDER ENROLLMENT APPLICATION – ATTACHMENT A

Provider Specialty List

Please review the list to find the primary and secondary specialty that best describes the service location being enrolled and record the specialty numbers in the appropriate fields in Schedule A, item 7.

> ***Note:*** *A secondary specialty may be designated only if it is included in the same provider type as the primary specialty.*

If you are an **INTERNIST** or **PEDIATRICIAN**, please also record your applicable subspecialty from the list in the space provided. If you do not have a subspecialty in these two categories, please choose **GENERAL INTERNIST (Specialty 344) or GENERAL PEDIATRICIAN (Specialty 345).**

Provider Type	Provider Specialty
01 Hospital	010 Acute Care Hospital
	011 Psychiatric Hospital
	012 Rehabilitation Hospital
02 Ambulatory Surgical Center	020 Ambulatory Surgical Center
03 Extended Care Center	030 Nursing Home/Nursing Facility
	031 Intermediate Care Facility for the Mentally Retarded (ICF/MR)
	032 Pediatric Nursing Facility
	033 Group Home/Residential Care Facility
04 Rehabilitation Facility	040 Rehabilitation Facility
05 Home Health Agency	050 Home Health Agency
06 Hospice	060 Hospice Agency
08 Clinic	080 Federally Qualified Health Clinic (FQHC)
	081 Rural Health Clinic (RHC)
	082 Medical Clinic
	083 Family Planning Clinic
	084 Nurse Practitioner Clinic
	085 Title V Clinic
	086 Dental Clinic
	087 Therapy Clinic

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Provider Type	Provider Specialty
09 Advanced Practice Nurse	090 Pediatric Nurse Practitioner
	091 Obstetric Nurse Practitioner
	092 Family Nurse Practitioner
	093 Nurse Practitioner (Other)
	094 Certified Registered Nurse Anesthetist (CRNA)
	095 Certified Nurse Midwife
10 Mid-Level Practitioner	**100 Physician Assistant
	**101 Anesthesiology Assistant
11 Mental Health Provider	110 Out Patient Mental Health Clinic
	111 Community Mental Health Center
	**112 Psychologist
	**113 Certified Psychologist
	114 Health Service Provider in Psychology (HSPP)
	**115 Master of Social Work (MSW)
	**116 Clinical Social Worker
	**117 Psychiatric Nurse
12 School Corporation	120 School Corporation
13 Public Health Agency	130 County Health Department
14 Podiatrist	140 Podiatrist
15 Chiropractor	150 Chiropractor
16 Nurse	160 Registered Nurse (RN)
	161 Licensed Practical Nurse (LPN)
	162 Registered Nurse Clinical (RNC)
17 Therapist	170 Physical Therapist
	171 Occupational Therapist
	*172 Respiratory Therapist
	173 Speech/Hearing Therapist
18 Optometrist	180 Optometrist
19 Optician	190 Optician
20 Audiologist	200 Audiologist
21 Case Manager	210 Care Coordinator for Pregnant Women
	211 HIV Case Manager
22 Hearing Aid Dealer	220 Hearing Aid Dealer
23 Dietitian	**230 Registered Dietitian
24 Pharmacy	240 Pharmacy
25 DME/Medical Supply Dealer	250 DME/Medical Supply Dealer

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Provider Type	Provider Specialty
26 Transportation Provider	260 Ambulance
	261 Air Ambulance
	262 Bus
	263 Taxi
	264 Common Carrier (Ambulatory)
	265 Common Carrier (Non-Ambulatory)
	266 Family Member
27 Dentist	270 Endodontist
	271 General Dentistry Practitioner
	272 Oral Surgeon
	273 Orthodontist
	274 Pediatric Dentist
	275 Periodontist
	277 Prosthesis
28 Laboratory	280 Independent Laboratory
	281 Mobile Laboratory
29 Radiology Provider	290 Freestanding X-Ray Clinic
	291 Mobile X-Ray Clinic
30 End Stage Renal Disease Clinic	300 Freestanding Renal Dialysis Clinic
31 Physician	310 Allergist
	311 Anesthesiologist
	312 Cardiologist
	313 Cardiovascular Surgeon
	314 Dermatologist
	315 Emergency Medicine Practitioner
	316 Family Practitioner
	317 Gastroenterologist
	318 General Practitioner
	319 General Surgeon
	320 Geriatric Practitioner
	321 Hand Surgeon
	322 Internist (with Subspecialty)
	Subspecialty List: Adult Critical Care Medicine Adolescent Medicine
	323 Neonatologist
	324 Nephrologist
	325 Neurological Surgeon

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Provider Type	Provider Specialty
	326 Neurologist
31 Physician (Cont.)	327 Nuclear Medicine Practitioner
	328 OB/GYN
	329 Hematologist/Oncologist
	330 Opthalmologist
	331 Orthopedic Surgeon
	332 Otologist, Laryngologist, Rhinologist
	333 Pathologist
	334 Pediatric Surgeon
	335 Pediatrician (with Subspecialty) Subspecialty List: Adolescent Medicine Diagnostic Lab Immunology Developmental Pediatrics Medical Toxicology Neonatal-Perinatal Medicine Pediatric Allergy Pediatric Cardiology Pediatric Critical Care Medicine Pediatric Dermatology Pediatric Emergency Medicine Pediatric Endocrinology Pediatric Gastroenterology Pediatric Hematology-Oncology Pediatric Infectious Diseases Pediatric Nephrology Pediatric Neurology Pediatric Otolaryngology Physical Medicine & Rehabilitation Pediatric Pulmonology Pediatric Rheumatology Pediatric Sports & Fitness Medicine Pediatric Urology
	336 Physician Medicine & Rehab Practitioner
	337 Plastic Surgeon
	338 Proctologist
	339 Psychiatrist
	340 Pulmonary Disease Specialist
	341 Radiologist

SAMPLE

Provider Type	Provider Specialty
	342 Thoracic Surgeon
	343 Urologist
31 Physician (Cont.)	344 General Internist (without Subspecialty)
	345 General Pediatrician (without Subspecialty)
32 Waiver Provider	350 Aged and Disabled Waiver
	351 Autism Waiver
	352 ICF/MR Waiver
	353 OBRA Developmentally Disabled Waiver
	354 Medically Fragile Children's Waiver
	356 Traumatic Brain Injury Waiver

** ***Note****: Provider types identified by ** are not eligible to receive a Medicaid number. Services they render under the supervision of an enrolled practitioner are billed with the appropriate modifier on a HCFA-1500 with the supervising practitioner's provider number in box 24K*

SAMPLE

SAMPLE

Indiana Health Coverage Programs

BILLING PROVIDER ENROLLMENT APPLICATION – ATTACHMENT B

***Note**: Requirements listed in* Italics *are not required for enrollment but are required for billing certain services. For example, a Clinical Laboratory Improvement Amendment (CLIA) Certificate is required for billing of laboratory services, and a federal Drug Enforcement Administration (DEA) Certificate is required for working with controlled substances.*

Provider Type	Specialties	In–State Provider Requirements	Out-of-state Provider Requirements
01 – Hospital	All	• Schedules A, B, and C.1 • Provider Agreement • Certificate and Transmittal sent directly to EDS from ISDH • Federal W-9 Tax Form • *CLIA Certificate (for laboratory work)* • *Drug Enforcement Administration (DEA) Certificate* • *HCFA letter to certify Distinct Part Unit if applicable*	Same as in–state requirements, except: • Copy of license from appropriate state • Proof of participation in state's Medicaid Program
02 – Ambulatory Surgical Center	All	• Schedules A, B, and C.1 • Provider Agreement • Copy of license from the Indiana State Department of Health • Certificate and Transmittal sent directly to EDS from ISDH • Federal W-9 Tax Form • *CLIA Certificate (for laboratory work)* • *Drug Enforcement Administration (DEA) Certificate*	• Same as in–state Requirements, except: Copy of license from appropriate state • Proof of participation in state's Medicaid Program
03 – Extended Care Facilities	All	• Schedules A, B, and C.1 • Provider Agreement • Certificate and Transmittal sent directly to EDS from ISDH • Federal W-9 Tax Form • *CLIA Certificate (for laboratory work)* • *Drug Enforcement Administration (DEA) Certificate*	IHCP does not enroll out-of-state Extended Care Facilities

SAMPLE

Provider Type	Specialties	In–State Provider Requirements	Out-of-state Provider Requirements
04 – Rehabilitation Facilities	All	• Schedules A, B, and C.1 • Provider Agreement • Certificate and Transmittal sent directly to EDS from ISDH • Federal W-9 Tax Form • *CLIA Certificate (for laboratory work)* • *Drug Enforcement Administration (DEA) Certificate*	IHCP does not enroll out-of-state Rehabilitation Facilities
05 – Home Health Agencies	All	• Schedules A, B, and C.1 • Provider Agreement • Certificate and Transmittal sent directly to EDS from ISDH • Federal W-9 Tax Form • *CLIA Certificate (for laboratory work)* • *Drug Enforcement Administration (DEA) Certificate*	IHCP does not enroll out-of-state Home Health Agencies
06 – Hospice	All	• Schedules A, B, and C.1 • Provider Agreement • Certificate and Transmittal sent directly to EDS from ISDH • Federal W-9 Tax Form • *CLIA Certificate (for laboratory work)* • *Drug Enforcement Administration (DEA) Certificate*	IHCP does not enroll out-of-state Hospice providers
08 – Clinics	080-FQHC	• Schedules A and B • Provider Agreement • FQHC approval letter from HCFA • Federal W-9 Tax Form • *CLIA Certificate (for laboratory work)* • *Drug Enforcement Administration (DEA) Certificate*	• Same as in–state requirements, except: Proof of participation in appropriate state's Medicaid Program or proof of participation in Medicare
	081-RHC	• Schedules A and B • Provider Agreement • Certificate and Transmittal sent directly to EDS from ISDH • Federal W-9 Tax Form • *CLIA Certificate (for laboratory work)* • *Drug Enforcement Administration (DEA) Certificate*	• Same as in–state requirements, except: Proof of participation in appropriate state's Medicaid Program or proof of participation in Medicare

SAMPLE

Provider Type	Specialties	In–State Provider Requirements	Out-of-state Provider Requirements
08 – Clinics (Cont.)	082 – 087	• Schedules A and B • Provider Agreement • Federal W-9 Tax Form • *CLIA Certificate (for laboratory work)* • *Drug Enforcement Administration (DEA) Certificate*	• Same as in–state requirements, except: Proof of participation in appropriate state's Medicaid Program or proof of participation in Medicare
09 – Advanced Practice Nurse	All	• Schedules A and B • Provider Agreement • Copy of current license from the Health Professions Bureau (HPB) • Federal W-9 Tax Form • *CLIA Certificate (for laboratory work)* • *Drug Enforcement Administration (DEA) Certificate if applicable*	• Same as in–state requirements, except: Copy of a current license from the appropriate state. • Proof of participation in appropriate state's Medicaid Program or proof of participation in Medicare
10 – Mid-Level Practitioner	All	• IHCP does not enroll these providers	IHCP does not enroll these providers
11 – Mental Health Provider	110 – Outpatient Mental Health Clinic	• Schedule A and B • Provider Agreement • Federal W-9 Tax Form • *CLIA Certificate (for laboratory work*) • *Drug Enforcement Administration (DEA) Certificate* • Outpatient Mental Health Addendum	• Same as in–state requirements, except: Proof of participation in appropriate state's Medicaid Program or proof of participation in Medicare
	111 – Community Mental Health Center	• Schedule A and B • Provider Agreement • Certification from IFSSA – Division of Mental Health • Federal W-9 Tax Form • *CLIA Certificate (for laboratory work)* • *Drug Enforcement Administration (DEA) Certificate* • Outpatient Mental Health Addendum	• Same as in–state requirements, except: Proof of participation in appropriate state's Medicaid Program or proof of participation in Medicare
	114 – HSPP (Health Service Provider in Psychology)	• Schedule A and B • Provider Agreement • Copy of current license from the Health Professions Bureau • Federal W-9 Tax Form	• Same as in–state requirements, except: Copy of current license from the appropriate state.
	All Others	• IHCP does not enroll these providers	IHCP does not enroll these providers

SAMPLE

Provider Type	Specialties	In–State Provider Requirements	Out-of-state Provider Requirements
12 – School Corporation	120 – School Corporation	• Schedule A and B • Provider Agreement • Federal W-9 Tax Form	IHCP does not enroll these providers
13 – Public Health Agency	130 – County Health Department	• Schedule A and B • Provider Agreement • Federal W-9 Tax Form • *CLIA Certificate (for laboratory work)*	IHCP does not enroll these providers
14 – Podiatrist	140 – Podiatrist	• Schedule A and B • Provider Agreement • Copy of license from the Health Professions Bureau • Federal W-9 Tax Form • *CLIA Certificate (for laboratory work)* • *Drug Enforcement Administration (DEA) Certificate*	• Same as in–state requirements, except: Copy of current license from the appropriate state.
15 – Chiropractor	150 – Chiropractor	• Schedule A and B • Provider Agreement • Copy of license from the Health Professions Bureau • Federal W-9 Tax Form	• Same as in–state requirements, except: Copy of current license from the appropriate state.
16 – Nurse	160 – Registered Nurse	• Schedule A and B • Provider Agreement • Copy of license from the Health Professions Bureau • Federal W-9 Tax Form	• Same as in–state requirements, except: Copy of current license from the appropriate state.
17 – Therapist	172 – Respiratory Therapist	• IHCP does not enroll these providers	• IHCP does not enroll these providers
	All other specialties	• Schedule A and B • Provider Agreement • Copy of license from the Health Professions Bureau • Federal W-9 Tax Form	• Same as in–state requirements, except: Copy of current license from the appropriate state.
18 – Optometrist	180 – Optometrist	• Schedule A and B • Provider Agreement • Copy of license from the Health Professions Bureau • Federal W-9 Tax Form	• Same as in–state requirements, except: Copy of current license from the appropriate state.
19 – Optician	190 – Optician	• Schedule A and B • Provider Agreement • Copy of license from the Health Professions Bureau • Federal W-9 Tax Form	• Same as in–state requirements, except: Copy of current license from the appropriate state.

SAMPLE

Provider Type	Specialties	In–State Provider Requirements	Out-of-state Provider Requirements
20 – Audiologist	200 – Audiologist	• Schedule A and B • Provider Agreement • Copy of license from the Health Professions Bureau • Federal W-9 Tax Form	• Same as in–state requirements, except: Copy of current license from the appropriate state.
21 – Case Manager	210 and 211	• Schedule A and B • Provider Agreement • Care Coordinator Certificate from National Association of Social Workers (NASW) • Federal W-9 Tax Form	IHCP does not enroll these providers
22 – Hearing Aid Dealer	220 – Hearing Aid Dealer	• Schedule A and B • Provider Agreement • Federal W-9 Tax Form • Copy of Hearing Aid Registration	• Same as in–state requirements, except: Copy of appropriate state's Hearing Aid Registration
23 – Registered Dietician	230 – Registered Dietician	IHCP does not enroll these providers	IHCP does not enroll these providers
24 – Pharmacy	240 – Pharmacy	• Schedule A and B • Provider Agreement • Copy of Indiana Pharmacy License • Federal W-9 Tax Form • Drug Enforcement Administration (DEA) Certificate	• Same as in–state requirements, except: Copy of current license from the appropriate state.
25 – DME	250 – DME	• Schedule A and B • Provider Agreement • Federal W-9 Tax Form	• Same as in–state requirements, except: Copy of current license from the appropriate state. • Must have at least one service location in the state of Indiana
26 – Transportation	260 – Ambulance	• Schedule A, B, and C.2 • Provider Agreement • Federal W-9 Tax Form • Copy of Indiana Emergency Medical Services (EMS) certificate	• Same as in–state requirements, except: Copy of appropriate state's Emergency Medical Services certificate
	261 – Air Ambulance	• Schedule A, B, and C.2 • Provider Agreement • Federal W-9 Tax Form • Copy of Indiana Air Emergency Medical Services (EMS) certificate	• Same as in–state requirements, except: Copy of appropriate state's Air Emergency Medical Services certificate

SAMPLE

Provider Type	Specialties	In–State Provider Requirements	Out-of-state Provider Requirements
26 – Transportation (Cont.)	262 – Bus	• Schedule A, B, and C.2 • Provider Agreement • Federal W-9 Tax Form • Copy of Motor Carrier Services (MCS) certificate	• Same as in–state requirements, except: Copy of appropriate state's certification for Buses
	263 – Taxi	• Schedule A, B, and C.2 • Provider Agreement • Federal W-9 Tax Form • Copy of license from Operating Authority of Local Governing Body	• Same as in–state requirements, except: Copy of license from Operating Authority of Local Governing Body
	264 (Ambulatory) and 265 (Non-Ambulatory) Common Carrier For Profit	• Schedule A, B, and C.2 • Provider Agreement • Federal W-9 Tax Form • Copy of Motor Carrier Services (MCS) certificate	• Same as in–state requirements, except: Copy of appropriate state's certification for common carriers
	264 (Ambulatory) and 265 (Non-Ambulatory) Common Carrier Not-For-Profit	• Schedule A, B, and C.2 • Provider Agreement • Federal W-9 Tax Form • Copy of Not-for-Profit Status from IRS • Proof of insurance	Same as in–state requirements
	266 – Family Member	• Schedule A, B, and C.2 • Provider Agreement • Local IFSSA Authorization Letter • Copy of insurance and copy of driver's license	Same as in–state requirements
27 – Dentist	All specialties	• Schedule A and B • Provider Agreement • Federal W-9 Tax Form • Copy of license from the Health Professions Bureau (HPB) • *CLIA Certificate (for laboratory work)* • *Drug Enforcement Administration (DEA) Certificate*	• Same as in–state requirements, except: Copy of current license from the appropriate state.
28 – Laboratory	All specialties	• Schedule A and B • Provider Agreement • Certificate and Transmittal sent directly to EDS from ISDH • Federal W-9 Tax Form • *CLIA Certificate (for laboratory work)* • *Drug Enforcement Administration (DEA) Certificate*	• Same as in–state requirements, except: Copy of current license from the appropriate state. • Proof of participation in appropriate state's Medicaid Program

SAMPLE

29 – Radiology	All specialties	• Schedule A and B • Provider Agreement • Radiology certificate • Certificate of compliance from the Indiana State Department of Health (ISDH) • Federal W-9 Tax Form • *CLIA Certificate (for laboratory work)*	• Same as in–state requirements, except: Copy of current license from the appropriate state. • Proof of participation in appropriate state's Medicaid Program
30 – Free Standing Renal Disease Clinic	300 – End Stage Renal Dialysis Clinic	• Schedule A and B • Provider Agreement • Certificate and Transmittal sent directly to EDS from ISDH • Federal W-9 Tax Form • *CLIA Certificate (for laboratory work)*	• Same as in–state requirements, except: Copy of current license from the appropriate state. • Proof of participation in appropriate state's Medicaid Program
31 – Physician	All specialties	• Schedule A and B • Provider Agreement • A copy of license from the Health Professions Bureau (HPB) • Federal W-9 Tax Form • *CLIA Certificate (for laboratory work)* • *Drug Enforcement Administration (DEA) Certificate*	• Same as in–state requirements, except: Copy of current license from the appropriate state.
32 – Waiver	All specialties	• Prior Enrollment as a Medicaid Provider • Approved application from the FSSA Waiver Unit	Same as in–state requirements

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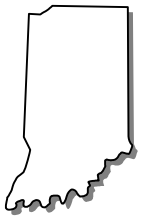
SAMPLE

Indiana Health Coverage Programs



ELECTRONIC FUNDS TRANSFER (EFT) FORM

Complete all fields on this form and attach a voided check or one of your bank deposit slips. The ABA transit routing number can be obtained from your bank.

Does the bank account listed below belong to a billing agency? ☐ Yes ☐ No

Provider Name _____ Provider Number _____

Provider Tax ID Number _____ ABA Transit Routing Number _____

Bank Name _____

Bank Address _____

Bank Account Number _____ Bank Account Name _____

Tax ID Number of Account Holder _____

Bank Telephone Number ( ) - Checking ☐ Savings ☐

Type of Authorization Start ☐ Cancel ☐ Change ☐

Is the change due to a change of ownership? ☐ Yes ☐ No

The following documents must be included with this form:

- **A voided check or a deposit slip**
- **A copy of a bank statement or other bank form displaying the tax ID on the bank account**

On behalf of the provider entity named above, I agree to keep, and disclose upon request to authorized agencies, records that fully disclose the extent of claim payments received from and services rendered to members of the Indiana Health Coverage Programs (IHCP). I accept as payment in full the amount paid by the IHCP for claims submitted with the exception of authorized cost sharing by members. I understand payment of IHCP claims are from state and federal funds and that any false claims, statements, documents or concealment of a material fact may be prosecuted under state or federal law. I ensure that this EFT request complies with the regulation set forth in 42 CFR 447.10, which prohibits State payments for any IHCP service to be made to anyone other than a Provider, a non-cash member, or to one of the listed exceptions. I understand that an IHCP payment may be sent via EFT to an account held by the following only: (1) to the Provider; (2) a non-cash member; (3) a government agency on reassignment by the Provider (IRS); (4) a third party by court order on reassignment by the Provider (child support); (5) a business agent (billing service, account firm) if three specific criteria are met (see page 2*); (6) the employer of the Practitioner (if a contract so requires); (7) a health care facility, or a health care delivery system (if a contract so requires) if the organization itself submits the claim directly to the IHCP.

EDS- Provider Enrollment
P. O. Box 68420
Indianapolis, IN 46268-0420

Form # PE0007G

I authorize the electronic transfer of IHCP payments (including 590, Medicaid and Package C) made to the above provider number. I understand that I am responsible for the validity of the above information. I agree to notify EDS within ten (10) days of any change in any of the information included on this form.

This section must be completed by an authorized officer or owner of the billing provider.

Printed Name & Title	*Telephone Number*
Signature	*Date*

Note: It will take approximately four weeks for this information to be processed by EDS and validated by your bank. Please send this form to the address listed in the bottom left corner of this form.

This section must be completed if a billing agent is receiving payment on behalf of the provider.

**The exception for a business agent is limited to agents who furnish statements and receive payments in the name of the provider, and the service provided by the agent is: (1) related to the cost of processing the bill; (2) not related to a percentage or other basis to the amount billed or collected; and (3) not dependent upon the collection of payment. Further, a payment for a provider may not be made to or through an individual or organization (collection agency or service bureau), or by power of attorney thereof, that advances money for accounts receivable that a provider has assigned, sold, or transferred to the organization for a fee or deduction of accounts receivable.*

If the EFT for the provider named on this document will be sent to a bank account belonging to a billing agent and not the bank account of the provider, you must complete the section below.

Billing Agent Name	Telephone Number	Billing Agent's Tax ID
Billing Agent Address		
Authorized Billing Agent Contact Name	Title	
Authorized Billing Agent Signature	Date	

EDS- Provider Enrollment
P. O. Box 68420
Indianapolis, IN 46268-0420

SAMPLE

List all Provider Names/Numbers linked to Tax Identification No.

****Tax Id. Number:** _____

Effective as of: _____

*****Must be accompanied with a W9 form***

******May be left blank if not assigned***

Group Member Name (Rendering)	**Group Provider Name (Billing)**	*****Provider Number**	**Location Code**

Form **W-9**
(Rev. December 2000)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Please print or type

Name (See **Specific Instructions** on page 2.)

Business name, if different from above. (See **Specific Instructions** on page 2.)

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 2.

***Note:** If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Social security number

or

Employer identification number

Part II For U.S. Payees Exempt From Backup Withholding (See the instructions on page 2.)

▶

Part III Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here Signature of U.S. person ▶ Date ▶

Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Corporations.

***Note:** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

What is backup withholding? Persons making certain payments to you must withhold and pay to the IRS 31% of such payments under certain conditions. This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. **Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part III instructions on page 2 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding **because** you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. **See the Part II instructions and the separate Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Part I—Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box.

If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are an LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

Note: *See the chart on this page for further clarification of name and TIN combinations.*

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office. Get Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS's Internet Web Site at www.irs.gov.

If you do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requestor. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requestor before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requestor.

Note: *Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.*

Part II—For U.S. Payees Exempt From Backup Withholding

Individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the separate Instructions for the Requester of Form W-9.

If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write "Exempt" in Part II, and sign and date the form.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requestor the appropriate completed Form W-8.

Part III—Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required).

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requestor, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requestor's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified state tuition program payments, IRA or MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 31% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account *
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor *
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee *
b. So-called trust account that is not a legal or valid trust under state law	The actual owner *
5. Sole proprietorship	The owner *
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship	The owner *
7. A valid trust, estate, or pension trust	Legal entity *
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

*List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

**Circle the minor's name and furnish the minor's SSN.

***You must show your individual name, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

****List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: *If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.*

SAMPLE

Indiana Health Coverage Programs

OUTPATIENT MENTAL HEALTH ADDENDUM (MUST BE COMPLETED BY PROVIDER TYPES 110-OUTPATIENT MENTAL HEALTH CLINIC AND 111-COMMUNITY MENTAL HEALTH CENTER)

The purpose of this addendum is to provide the Indiana Health Coverage Programs (IHCP) a complete list of individual practitioners who provide outpatient mental health services and their qualifications. The IHCP requires that this addendum be completed by all outpatient mental health facilities or clinics, or community mental health centers, during the provider enrollment process.

Pursuant to IC 5-20-8, Medicaid reimbursement is available for outpatient mental health services provided by licensed physicians, psychiatric hospitals, psychiatric wings of acute care hospitals, outpatient mental health facilities, and psychologists endorsed as a health service provider in psychology (HSPP). Outpatient mental health services rendered by a medical doctor, doctor of osteopathy, or HSPP are subject to the following limitations:

1. Outpatient mental health services rendered by a medical doctor or doctor of osteopathy are subject to the limitations set out in 405 IAC 5-25.
2. Subject to prior authorization by the office or its designee, Medicaid will reimburse physician or HSPP directed outpatient mental health services for group, family, and individual outpatient psychotherapy when such services are provided by one of the following practitioners:
   - A licensed psychologist
   - A licensed independent practice school psychologist
   - A licensed clinical social worker
   - A licensed marital and family therapist
   - A licensed mental health counselor
   - A person holding a masters degree in social work, marital and family therapy, or mental health counseling
   - An advanced practice nurse who is a licensed, registered nurse holding a masters degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing
3. The physician, psychiatrist, or HSPP is responsible for certifying the diagnosis and for supervising the plan of treatment described as follows:
   - The physician, psychiatrist, or HSPP is responsible for seeing the recipient during the intake process or reviewing the medical information obtained by the practitioner listed in subdivision (2) within seven days of the intake process. This review by the physician, psychiatrist, or HSPP must be documented in writing.
   - The physician, psychiatrist, or HSPP must again see the patient or review the medical information and certify medical necessity on the basis of medical information provided by the practitioner listed in subdivision (2) at intervals not to exceed ninety (90) days. This review must be documented in writing.
4. The supervising physician or HSPP must provide his or her IHCP provider number and a copy of his or her license.

SAMPLE

Supervising Physician or HSPP

You must complete the following information for the supervising physician or HSPP.

Practitioner's Name	IHCP Provider Number	Relationship (Contractor or Employee)	Provider Specialty (Physician or HSPP)

I, the undersigned, certify that I have read and understand the Outpatient Mental Health Addendum. I further certify that I am an employee or contractor of this clinic and supervise all plans of treatment as required by law and outlined in this addendum.

Signature of Supervising Practitioner **Date**

Employees or Contracting Practitioners

You must complete the following information. Please list below the practitioner's name, provider number (if available), practitioner type, and license type and number for all physician and/or other practitioners in your outpatient facility or clinic.

The supervising physician or HSPP must provide his/her IHCP provider number or a copy of his/her license. For any mid-level practitioners, you must denote the provider type (such as psychologist, social worker, etc.). Please attach an additional page if more space is needed.

Practitioner's Name (mandatory) & IHCP Provider Number (if available)	Provider Type	Qualifications: License Type & Number

SAMPLE

You must complete the following section prior to submitting the addendum to EDS. Any addendum received by EDS without complete information will be returned to the provider. You must submit this form with your IHCP Provider Enrollment Application.

I, the undersigned on behalf of the provider, have read and understand the Outpatient Mental Health Addendum. I further certify that each practitioner listed on this list is an employee or contractor of our facility, each of these practitioners has been informed of the IHCP policy for reimbursement of outpatient mental health services, and each practitioner, whether employed or contracted, understands that he or she will be reimbursed for services by our facility. I further certify that all information provided is accurate to the best of my knowledge.

This section must be completed by an authorized officer or owner of the billing provider.

Printed Name of person completing the addendum:	**Printed Title:**
Signature of person completing the addendum:	**Date:**
Name of outpatient mental health clinic/community mental health center:	**Clinic Provider Number**

SAMPLE

EDS
P. O. Box 68420
Indianapolis, IN 46268-0420

SAMPLE

Certification Statement for Providers Submitting Claims

This is to certify that any and all information contained on any Medicaid or Children's Health Insurance Program (CHIP) billings submitted on my behalf by electronic, telephonic, mechanical, and/or standard paper means of submission shall be true, accurate, and complete. I accept total responsibility for the accuracy of all information obtained on such billings, regardless of the method of compilation, assimilation, or transmission of the information (i. e. either by myself, my staff, and/or a third party acting in my behalf, such as a service bureau). I fully recognize that any billing intermediary, or service bureau that submits billings to the Family and Social Services Administration (FSSA) or its Fiscal Agent Contractor is acting as my representative and not that of FSSA or its Fiscal Agent Contractor. I further acknowledge that any third party that submits billings on my behalf shall be deemed to be my agent for purposes of submission of Medicaid and CHIP claims.

I understand that payment and satisfaction of any claims that shall be submitted on my behalf will be from Federal and State funds, and that any false claims, statements, documents, or concealment of material fact may be prosecuted under applicable Federal and/or State law. The provider will hold harmless and indemnify FSSA from any and all claims, actions, damages, liabilities, costs and expenses, including reasonable attorneys' fees and expenses, which arise out of or are alleged to have arisen out of or as a consequence of the submission of Medicaid or CHIP billings by the provider through electronic, telephonic, mechanical, and/or standard paper means of submission unless the same shall have been caused by negligent acts or omissions of FSSA.

I acknowledge that the fees and charges paid to providers for all medical services rendered or materials supplied shall be in accordance with Federal and State law and regulation with recognition of the provider's traditional right to charge for services rendered. I hereby certify that the charges submitted upon my claims shall be my usual and customary charges for my services with recognition of the provider's traditional right to charge for his services. I am aware of the restricted funding of the Indiana Health Coverage Programs, and I agree to accept as full payment for any services billed on any claims, the payment allowance determined by either the Indiana Health Coverage Programs Fiscal Agent Contractor, or the Indiana Health Coverage Programs Rate Setting Contractor.

I further certify that no supplemental charges will be billed to any Indiana Health Coverage Programs member or to the family of any member for any covered service of the Indiana Health Coverage Programs, except for copayment, patient liability payments, and any other patient payments as required by law.

I agree to keep such records as may be necessary to fully disclose the extent of services provided to individuals under the Indiana Health Coverage Programs, and to furnish such information regarding any Medicaid or CHIP payments claimed for providing such services to FSSA or its designee, upon request, for a period not less than three years from the date of service, or any such period FSSA may require. In those cases when information substitutes are allowed, I further acknowledge that I will maintain all required supporting claim documentation in my place of business and make such documentation available for review by FSSA or its Fiscal Agent Contractor. I agree to keep records independent of any paper claims, tapes, telephonic submission, or other electronic media that have been sent to its Fiscal Agent Contractor for claims payment, to document the accuracy of the service for which I have billed the Indiana Health Coverage Programs. I agree to submit such records as may be required by FSSA or the Federal Government.

I understand that FSSA or its designees are prepared to provide necessary technical assistance to assist new providers, or to correct technical problems which existing providers may experience. I realize that all communications regarding electronic, telephonic, mechanical, or standard paper submission of claims shall be between the provider in whose name the claim is submitted and FSSA or its Fiscal Agent Contractor. I further understand that this technical assistance shall consist of:

- Identification of data element requirements
- Identification of record layouts and other electronic specifications
- Identification of systematic problem areas and recommended solutions

I agree to execute a separate Certification Statement for each Indiana Health Coverage Programs (IHCP) provider number that has been issued to me. I also agree to notify either FSSA or its Fiscal Agent Contractor of any changes in my provider name or address. Further, I agree to comply with such minimum substantive and procedural requirements for claims submission as may be required by FSSA or its Fiscal Agent Contractor.

I understand that the standard paper claim form may include a signature line. I understand that all of the stipulations, conditions, and terms of the certification statement apply in the even that I fail, for any reason, to sign the paper claim and the claim is approved for payment. I agree that payment of a paper claim that did not contain my signature, in no way absolves me of the terms stated herein to which I have agreed.

I recognize that any difference of opinion concerning the amount of Indiana Health Coverage Programs payment for any claim must be adjudicated as provided in Indiana Code 4-21.5-3. Further I understand that violation of any of the provisions of this Certification Statement shall subject me to the sanctions set out in Indiana Code 12-15-22-1 and shall make the billing privilege established by this document subject to immediate revocation at FSSA's option.

THE UNDERSIGNED HAVING READ THIS CERTIFICATION STATEMENT AND UNDERSTANDING IT IN ITS ENTIRETY DOES HEREBY AGREE TO ALL OF THE STIPULATIONS, CONDITIONS AND TERMS STATED HEREIN.

Provider Name

Title

EDS
P. O. Box 7263
Indianapolis, IN 46207-7263

For more information visit www.indianamedicaid.com

SAMPLE

Provider Signature | Date | IHCP Provider Number/Service Location

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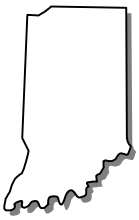
Indiana Health Coverage Programs



ENROLLMENT APPLICATION CHECKLIST

The following checklist contains the most common reasons Indiana Health Coverage Programs (IHCP) enrollment applications are returned. Please use this checklist to review enrollment applications before sending to the IHCP.

Did you remember to…

- ☐ Include a copy of your professional license, if applicable
- ☐ Sign the provider agreement
- ☐ Include a copy of your DEA certificate for prescription referral or billing
- ☐ Include a copy of your CLIA certificate for laboratory services
- ☐ Complete Schedules A, B, and as appropriate, Schedule C
- ☐ Indicate *only one* provider type on Schedule A
- ☐ Indicate *one primary* provider specialty and secondary specialties as applicable
- ☐ Include a list of practice locations for all new group members
- ☐ Include a list of all members for new group enrollments
- ☐ Include a copy of W-9 form for tax identification purposes
- ☐ Include a copy of your Medicare Assignment Letter.

Thank you for your participation in the IHCP.

EDS
P. O. Box 68420
Indianapolis, IN 46268-0420

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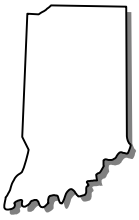
Indiana Health Coverage Programs



C H A N G E O F O W N E R S H I P A D D E N D U M

If you have recently undergone or are undergoing a Change of Ownership, please complete this form and enclose a copy of the purchase agreement with your enrollment application.

Change of Ownership Type:

☐ Acquisition ☐ Merger* ☐ Acquisition of Assets Only

Effective Date

Provider Number Changing Ownership

Provider Name Changing Ownership

Service Location (Alpha Suffix) Changing Ownership

Old Tax ID

New Tax ID

Group Members remaining under new ownership

Provider Number	Provider Name

*Mergers: Please complete additional copies as needed for each group or practice merging into the new Tax ID.

Please, contact Customer Assistance at (317) 655-3240 or 1-800-577-1278 with any questions.

SAMPLE